Motor Vehicle Accident History

PATIENT NAME:			DATE:
ADDRESS:		CITY:	STATE/ZIP CODE:
HOME PHONE NUMBER:		CELL PHONE NUMBER:	
SOCIAL SECURITY NUMBER:	DATE OF BIRTH:	AGE:	GENDER:
EMERGENCY CONTACT NAME:		EMERGENCY CONTACT PHONE NUMBER:	
EMPLOYER NAME:		EMPLOYER ADDRESS:	

ACCIDENT INFORMATION

DATE OF ACCIDENT:	TIME OF ACCIDENT:	WHERE WERE YOU LOCATED IN THE VEHICLE AT THE TIME OF THE ACCIDENT? ❑ DRIVER ❑ PASSENGER ❑ FRONT SEAT ❑ BACK SEAT
NUMBER OF PEOPLE IN THE CAR:	NAMES OF PEOPLE IN THE CAR WITH YOU:	
WHAT DIRECTION WAS YOUR CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		ON WHAT STEET WERE YOU HEADED?
WHAT DIRECTION WAS THE OTHER CAR HEADED? ❑ NORTH ❑ SOUTH ❑ EAST ❑ WEST		WERE YOU STRUCK FROM: ❑ BEHIND ❑ FRONT ❑ LEFT SIDE ❑ RIGHT SIDE
WERE YOU KNOCKED UNCONSCIOUS? ❑ YES ❑ NO		DID YOU HIT YOUR HEAD? ❑ YES ❑ NO
WHERE WERE YOU TAKEN AFTER THE ACCIDENT?		BY AMBULANCE: ❑ YES ❑ NO
WERE THE POLICE ON THE SCENE? ❑ YES ❑ NO	WAS A REPORT FILED? ❑ YES ❑ NO	DO YOU HAVE A COPY? ❑ YES ❑ NO
HAVE YOU BEEN TREATED BY ANY OTHER DOCTORS FOR THIS ACCIDENT? ❑ YES ❑ NO		SINCE THE INJURY, ARE YOUR SYMPTOMS: ❑ IMPROVING ❑ GETTING WORSE ❑ GETTING BETTER
HAVE YOU LOST TIME FROM WORK? ❑ YES ❑ NO		DATE YOU LEFT WORK: / DATE YOU RETURNED TO WORK:
HAVE YOU BEEN INVOLVED IN AN ACCIDENT IN THE PAST? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY PREVIOUS ILLNESSES WHICH RELATE TO THIS CASE? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:
DO YOU HAVE ANY ACTIVITY RESTRICTIONS AS A RESULT OF THIS INJURY? ❑ YES ❑ NO		IF YES, PLEASE DESCRIBE:

INSURANCE INFORMATION

AUTO INSURANCE COMPANY NAME:	
ADJUSTER NAME:	ADJUSTER PHONE NUMBER:
POLICY NUMBER:	CLAIM NUMBER:

What is your chief complaint:_____

When did your symptoms first appear?_____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

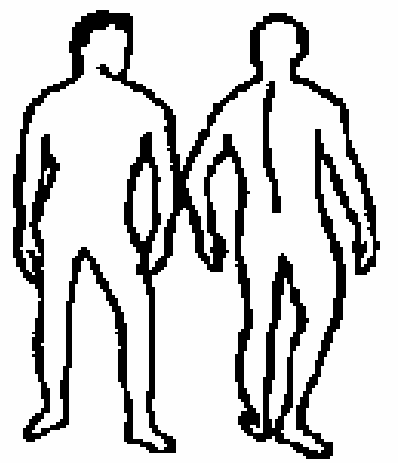
What type of pain are you experiencing?
Sharp Dull Throbbing Ache Shooting Tingling
Numbness Stiff

Does it interfere with your: Work Sleep Daily Routine

Activities or movements that are difficult to perform:
Sitting Standing Walking Bending Lying Down

Is pain radiating: Y / N. If Yes, Where:
R. Arm L. Arm R. Leg L. Leg

Mark an "X" on the picture where you continue to



Additional complaint:_____

When did your symptoms first appear?_____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

What type of pain are you experiencing?
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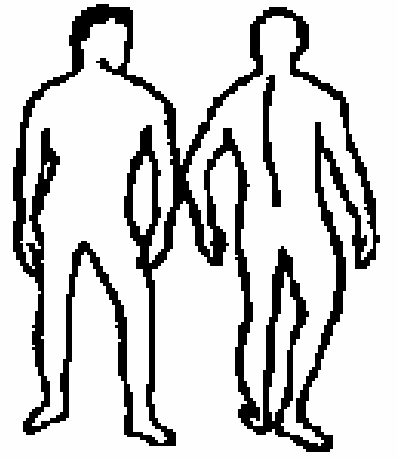

Additional complaint:_____

When did your symptoms first appear?_____

Is this condition: Getting Worse Stays the Same Comes and Goes Unbearable

Rate the severity of your discomfort on a scale of 0-10, 10 being the most discomfort/severe: 0 1 2 3 4 5 6 7 8 9 10

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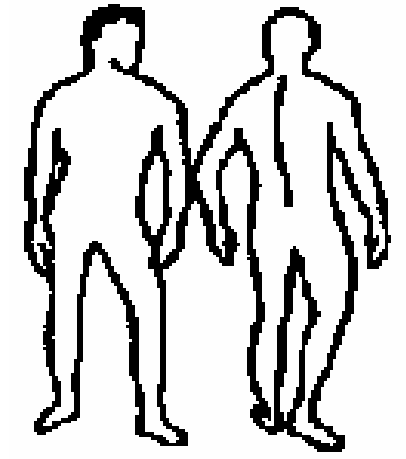


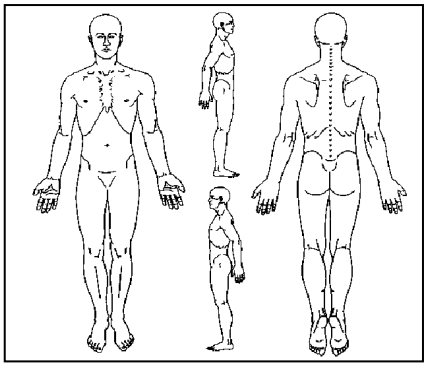
ACCIDENT INFORMATION

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS:

INSTRUCTIONS: *CHECK (✓) ANY/ALL SYMPTOMS NOTED AFTER THE ACCIDENT.*

- ❑ HEADACHE
- ❑ NECK PAIN
- ❑ NECK STIFFNESS
- ❑ SLEEPING PROBLEMS
- ❑ BACK PAIN
- ❑ NERVOUSNESS
- ❑ TENSION
- ❑ IRRITABILITY
- ❑ CHEST PAIN
- ❑ DIARRHEA
- ❑ CONSTIPATION
- ❑ FEVER
- ❑ DIZZINESS
- ❑ HEAD SEEMS HEAVY
- ❑ PINS & NEEDLES IN ARMS
- ❑ PINS & NEEDLES IN LEGS
- ❑ NUMBNESS IN FINGERS
- ❑ NUMBNESS IN TOES
- ❑ SHORTNESS OF BREATH
- ❑ FATIGUE
- ❑ DEPRESSION
- ❑ FEET FEEL COLD
- ❑ HANDS FEEL COLD
- ❑ COLD SWEATS
- ❑ LIGHT BOTHERS EYES
- ❑ LOSS OF MEMORY
- ❑ EARS RING
- ❑ FACE FLUSHED
- ❑ BUZZING IN EARS
- ❑ LOSS OF BALANCE
- ❑ FAINTING
- ❑ LOSS OF SMELL
- ❑ LOSS OF TASTE
- ❑ UPSET STOMACH
- ❑ OTHER: _____
- ❑ OTHER: _____

INTRUCTIONS: *Please mark the area and type of pain on the drawings using the codes listed below:*
N=Numbness P=Pain A=Ache T=Tingling S=Stiffness/Soreness



COMMENTS:

PLEASE PROVIDE ANY OTHER PERTINENT INFORMATION YOU THINK WE SHOULD KNOW:

DOCTOR ONLY

DOCTOR COMMENTS:

SIGNATURE

PATIENT SIGNATURE:	DATE:

Quint Chiropractic
3822 Oleander Drive
Wilmington, NC 28403

INFORMED CONSENT FOR CHIROPRACTIC TREATMENT

I understand that, as in the practice of medicine, in the practice of chiropractic care there are some risks to treatment, including and not limited to, fractures, disc injuries, strokes, dislocations and sprains. I do not expect the doctor to anticipate and explain all risks and complications. I wish to rely on the doctor to exercise judgment during the course of the procedure which the doctor feels at the time, based on the facts then known, is in my best interest.

By signing below I agree to the above and allow the doctor, affiliated with Quint Chiropractic, to perform such. This consent will cover the entire course of my treatment.

Patient Name: _____ *Date:*_____

*Patient or Guardian Signature:*_____ *Date:*_____

AUTHORIZATION FOR CARE

I hereby authorize the Doctor to work with my condition through the use of adjustments to my spine, as he or she deems appropriate. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I agree that I am responsible for all bills incurred at this office. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis. I also understand that if I suspend or terminate my care, any fees for professional services rendered me will become immediately due and payable.

I hereby authorize assignment of my insurance rights and benefits (if applicable) directly to the provider for services rendered. I understand and agree that health and accident insurance policies are an arrangement between an insurance carrier and myself. I understand that the Doctor's Office will prepare any necessary reports and forms to assist me in collecting from the insurance company and that any amount authorized to be paid directly to the Doctor's Office will be credited to my account on receipt.

Ownership of X-ray Films: *It is understood and agreed that the payments to the Doctor for X-rays is for examination of X-rays only. The X-ray negative will remain the property of the office. They are kept on file where they may be seen at any time while I am a patient at this office.*

SIGN IF READ ABOVE _____ DATE_____

NOTICE OF PRIVACY POLICY

Protecting the privacy of your personal health information is important to us. Disclosure of your protected health information without authorization is strictly limited to defined situations that include emergency care, quality assurance activities, public health, research, and law enforcement activities. Any other disclosures for the purposes of treatment, payment or practice operations will be made only after obtaining your consent.

- You may request restrictions on your disclosures.
- You may inspect and receive copies of your records within 30 days with a request.
- You may request to view changes to your records.
- In the future, we may contact you for appointment reminders, announcements and to inform you about our practice and its staff.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow up with multiple healthcare providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operations such as quality assessments and physician's certifications.

I have read and understand your Notice of Privacy Practices. A more complete description can be requested. I also understand that I can request, in writing, that you restrict how my personal information is used and or disclosed.

PATIENT NAME (PLEASE PRINT):	RELATIONSHIP TO PATIENT:
SIGNATURE:	DATE: